

PATIENT HISTORY FORM

Date: _____

NAME: _____ **AGE:** _____ **Sex:** M _____ F _____

How were you referred to our office? **Physician** _____ **Magazine** _____ **Internet** _____ **Newspaper** _____ **TV** _____ **Other** _____

Name of Referring Physician: _____

Your Primary Care Physician: _____ Cardiologist: _____

CHIEF COMPLAINT

REASON FOR TODAY'S VISIT: _____

WHEN DID YOUR INJURY OR PROBLEM BEGIN? _____

DO YOU CONSIDER THIS WORK RELATED: _____ Yes _____ No When was it reported to your employer? _____

PATIENT MEDICAL HISTORY

LIST ANY MEDICAL PROBLEMS YOU HAVE: _____

LIST ALL MEDICATION YOU ARE TAKING

NAME OF MEDICATION	DOSE	HOW OFTEN	REASON

DO YOU HAVE ANY ALLERGIES? _____ Yes _____ NO

ASPIRIN _____ SULFA _____ PENICILLIN _____ ANESTHETIC _____ LATEX _____ OTHER _____

PAST SURGERIES: _____

Any Anesthesia problems _____

FAMILY HISTORY

What illnesses run in your family? _____

SOCIAL HISTORY

Are you : Right _____ or Left _____ handed?

Occupation: _____ Employed by: _____

Married _____ Widowed _____ Divorced _____ Separated _____ Single _____ How many children? _____

How much do you Smoke? _____ How much Alcohol do you Drink? _____

Have you ever used street drugs? Yes _____ No _____ If so when was the last time? _____ What drug? _____

Do you exercise? Yes _____ No _____

Recent weight gain? Yes _____ No _____ Recent Weight Loss? Yes _____ No _____ Intentional ? Yes _____ No _____

Do you use a: Wheelchair _____ Walker _____ Cane _____ Who do you live with? _____

PHYSICAL EXAM

Pulse _____ RR _____ Temp _____ Pain _____ Height _____ Weight _____